4901.50 WORKSHEET S-4 - SNF-BASED HOME HEALTH AGENCY STATISTICAL DATA

Worksheet S-4 consists of the following four parts:

Part I - Visits and Census Data
Part II - Employment Data FTEs
Part IIII - CBSA Data
Part IV - PPS Activity Data

In accordance with 42 CFR 413.20 and 42 CFR 413.24, you are required to maintain statistical records for proper determination of costs payable under titles XVIII and XIX. The statistics required on this worksheet pertain to a SNF-based HHA. For Part I, the statistical data to be maintained, depending on the services provided by the SNF-based HHA, includes the number of program visits, total number of HHA visits, number of program home health aide hours, total home health aide hours, program patient census count, total patient census count, program patient unduplicated census count, and total patient unduplicated patient count. Part II collects required FTE data by employee staff, contracted staff, and total staff. Part III identifies the total number of CBSAs where Medicare services were provided. Part IV identifies PPS-activity data. Complete a separate Worksheet S-4 for each SNF-based HHA.

Definitions.

HHA Visits.--A visit is an episode of personal contact with the patient by staff of the SNF-based HHA, or others under arrangements with the SNF-based HHA, for the purpose of providing a covered home health service as described in 42 CFR 409.45 (b) through (g). Medicare type visits generally fall under the definition of Medicare visits as described in 42 CFR 409.48. In counting Medicare type visits, it is critical that non-Medicare visits are of the same type as those that would be covered by Medicare. This ensures that costs of services are comparable across insurers and that costs are apportioned appropriately between Medicare and non-Medicare. A visit is initiated with the delivery of covered home health services and ends at the conclusion of delivery of covered home health services. In those circumstances in which all reasonable and necessary home health services cannot be provided in the course of a single visit, SNF-based HHA staff or others providing services under arrangements with the SNF-based HHA may remain at the patient's home between visits (e.g., to provide non-covered services). However, if all covered services could be provided in the course of one visit, only one visit may be covered. (See 42 CFR 409.48(c)(4)).

Patient Census.--Each patient is counted once for each type of service during the cost reporting period. For example, if a patient receives multiple Medicare covered skilled nursing visits from a registered nurse and multiple Medicare covered medical social service visits, he or she is counted only once in column 2 for the corresponding service. Another example is if a patient receives both covered services and non-covered services, he or she is counted once as title XVIII (for covered services), once as other (for non-covered services), and only once as total.

Unduplicated Census Count.--Each patient is counted only once, no matter how many SNF-based HHA services each receives during the cost reporting period. A patient who receives HHA services throughout the year should be counted and reported no more than one time. The unduplicated census count answers the question: How many patients did the SNF-based HHA serve during this cost reporting period?

Use lines 1 through 10 to identify the number of visits and corresponding patient census count. The patient census count in columns 2, 4, 6, and 8 includes each individual who received each type of service. Include each individual patient only once for each type of service. For example, if a patient receives multiple Medicare covered skilled nursing visits from a registered nurse and multiple Medicare covered medical social service visits, he or she is counted only once in column 2 for the corresponding service. The sum of the patient census counts in column 8 minus columns 2, and 4 will equal column 6. The total of lines 1 through 9 for columns 2 and 4 and the total of lines 1 through 10 for columns 6 and 8 may not necessarily equal line 13, unduplicated census count, since many patients receive more than one type of service. Beneficiaries who experience multiple spells of illnesses (multiple visits, multiple episodes, and/or multiple discharges and admissions) within a cost reporting period must be counted only once in the unduplicated census count.

4901.51 Part I - Visits and Census Data.

Columns 1 and 2.--Enter data pertaining to title XVIII-Medicare beneficiaries only. Enter in column 1 all Medicare visits rendered during the entire cost reporting period. See CMS Pub. 100-02, chapter 7, §70.2, for visit count determination. For each line, enter in column 2 the patient census count applicable to the Medicare visits reported in column 1.

Columns 3 and 4.--Enter data pertaining to title XIX-Medicaid patients only. Enter in column 3 all Medicaid visits rendered during the entire cost reporting period. For each line, enter in column 4 the patient census count applicable to the Medicaid visits reported in column 3.

Columns 5 and 6.--Enter data pertaining to Medicare Managed Care, Medicaid Managed Care, and all other patients. Do not include data reported in columns 1 through 4. Enter in column 5 all visits from patients not covered by Medicare (reported in column 1) or Medicaid (reported in column 3). For each line, enter in column 6 the patient census count applicable to all other patient visits reported in column 5.

Columns 7 and 8.--Enter total agency visits and patient census count. Enter in column 7, all visits rendered for all patients during the cost reporting period for each discipline. For each line, enter in column 8, the patient census count for all patients during the cost reporting period. The sum of columns 1, 3, and 5 must equal column 7. The sum of columns 2, 4, and 6 may not equal column 8. For example, if a patient receives both Medicare covered services (columns 1 and 2) and Medicare non-covered services (columns 5 and 6), he or she is counted once in column 2 (for covered services), once in column 6 (for non-covered services), and once in column 8, total.

Lines 1 through 9.--These lines identify the type of home health service rendered to patients. The entries reflect the number of visits furnished and the number of patients receiving a particular type of service.

Line 10.--This line may not be used for columns 1 through 4. Enter in columns 5 and 7 the total of all other visits provided by the SNF-based HHA. Enter in columns 6 and 8 the patient census count applicable to visits furnished by the SNF-based HHA.

Line 11.--Enter the sum of lines 1 through 9 for each of columns 1 and 3. Enter the sum of lines 1 through 10 for each of columns 5 and 7.

Line 12.--Enter the number of hours applicable to home health aide services.

Line 13.--Enter the unduplicated count of all patients receiving home visits or other care provided by employees of the SNF-based HHA or under contractual arrangement in the appropriate column for the entire cost reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count may not equal the sum of the title XVIII and all other patient census counts. For purposes of calculating the unduplicated census count, if a beneficiary has received health care by more than one HHA, you must prorate the unduplicated census count based on the ratio of visits provided by this SNF-based HHA to the total visits furnished to the beneficiary by all HHAs so as to not exceed a total of one. For example, if an HHA furnishes 100 visits to an individual beneficiary in Maryland during the cost reporting period and the same individual received a total of 400 visits (the other 300 visits were furnished in Florida during the cost reporting period), the reporting HHA would count the beneficiary as a .25 (100 divided by 400) in the unduplicated census count for Medicare beneficiaries for the cost reporting period. Round the result to two decimal places, e.g., .2543 is rounded to .25. A SNF-based HHA must query the beneficiary to determine if he or she has received health care from another HHA during the year, i.e., Maryland versus Florida for beneficiaries with seasonal residence.

4901.52 Part II - Employment Data FTEs.

Line 1.--Enter the total number of hours in a normal workweek (i.e. 40 hours per week or 35 hours per week).

Line 2 through 20.--Provide statistical data related to the human resources of the SNF-based HHA. The human resources statistics are required for each of the job categories specified on lines 2 through 19. Enter any additional categories needed on line 20 and its subscripts.

Report in column 1 the FTE employees on the SNF-based HHA's payroll. These are staff for which an IRS Form W-2 is issued.

Report in column 2 the FTE contracted and consultant staff of the SNF-based HHA.

Compute staff FTEs for column 1 as follows: Add all hours for which employees were paid and divide by 2080 hours. Round to two decimal places, e.g., .04447 is rounded to .04. Compute contract FTEs for column 2 as follows: add all hours for which contracted and consultant staff worked and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

4901.53 Part III - CBSA Data.

Line 1--Enter the total number of CBSAs where Medicare covered services were provided during this cost reporting period. CBSA codes are five-character numeric codes that identify the geographic area at which Medicare covered services are furnished. Obtain these codes from your contractor.

Line 2.--List all CBSA codes where Medicare covered home health services were provided during the cost reporting period. Line 2 contains the first code. Enter one CBSA code on each line. If additional lines are needed, subscript line 2 beginning with lines 2.01, 2.02 etcetera, as necessary, entering one CBSA code on each subscripted line. Obtain these codes from your contractor.